(On Employer Letterhead)
Extended Coverage Election Notice

Date:

Address this notice as appropriate to:
- **The employee, or**
- **The employee and spouse, or**
- **The employee, spouse and family, or**
- **The spouse or child who is losing coverage**

At the mailing address(es) of record

Dear **(Insert Name and/or Status of Qualified Beneficiary/ies):**

This notice contains important information about your right to continue your health care coverage in The Local Choice (TLC) Health Benefits Program (the Plan) sponsored by (**Insert Name of Local Employer**). Please read the information contained in this notice very carefully.

To elect Extended Coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it, along with your TLC Enrollment Form, to your Group Benefits Administrator noted at the bottom of this page. Additional resources are included in the attachment, Important Information About Your Extended Coverage Rights.

If you do not elect Extended Coverage, your coverage under the Plan will end on **(Enter date coverage would be lost due to the qualifying event*)*** due to:

- ❑ End of employment
- ❑ Reduction in hours of employment resulting in loss of coverage (including loss of or change to employer premium contribution)
- ❑ Death of employee or retiree
- ❑ Divorce from the employee or retiree
- ❑ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect Extended Coverage, which will continue group health care coverage under the Plan for up to **(Insert 18 or 36)** months:

- ❑ Employee or former employee
- ❑ Spouse or former spouse
- ❑ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ❑ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, Extended Coverage will begin on **(Insert date)** and can last until **(Insert date)**. At the start of your Extended Coverage period, you may elect any of the plan options offered by (**Insert Name of Local Employer**).

Attached is a premium rate summary that provides the cost for Extended Coverage based on the elected membership level and plan. You do not have to send any payment with the Election Form. Important additional information about payment for Extended Coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to Extended Coverage, you should contact:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

Extended Coverage Election Form

INSTRUCTIONS: To elect Extended Coverage, complete this Election Form and return it to your Group Benefits Administrator listed on page one of this notice. By law, you must have 60 days after the date of this notice (or from the date that coverage is lost due to the qualifying event, whichever is later) to decide whether you want to elect Extended Coverage under the Plan.

This means that this form, along with a The Local Choice Health Benefits Program Enrollment Form (enclosed), must be delivered to your Group Benefits Administrator by **(Insert end of 60-day enrollment period)**. An Election Notice and Enrollment Form that are mailed will be considered timely if postmarked by that date. If they are hand-delivered, they will be considered timely if received by the Group Benefits Administrator by that date.

If you do not submit a completed Election Form and Enrollment Form by the due date shown above, you will lose your right to elect Extended Coverage. (If you have elected an alternative coverage that runs concurrently with Extended Coverage, such as coverage while on leave, and that coverage will be exhausted before the end of the maximum Extended Coverage period available to you, see your Group Benefits Administrator for additional information.) If you decline Extended Coverage before the due date, you may change your mind as long as you furnish a completed Election Form and Enrollment Form before the due date. However, if you change your mind after first rejecting Extended Coverage, your Extended Coverage will not begin until the first of the month after you furnish the completed forms.

Be sure to read the important information about your Extended Coverage rights included in the pages following this Election Form.

I (We) elect or decline Extended Coverage as indicated below. If coverage is elected, please check whether you will continue Medical Coverage:

Name	Date of Birth	Current ID Number	Social Security No.	Elect Medical (√)	Decline (√)
Employee*:					
Spouse:					
Child:					
Child:					
Child:					

If additional qualified beneficiaries should be listed, please attach a separate sheet.

_____ _____

**Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____ _____

Print Address Telephone Number

*If the employee became entitled to Medicare (Part A or B) within the 18 months prior to termination of employment or reduction of hours, please indicate eligibility date here _____.

**A covered employee may elect coverage on behalf of his/her eligible spouse, and parents may elect on behalf of their eligible children. Indicate individual elections on the Enrollment Form(s).

IMPORTANT INFORMATION ABOUT YOUR EXTENDED COVERAGE RIGHTS

What is Extended Coverage?

Federal law requires that most group health plans (including this Plan) give employees/former employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, the covered employee's or former employee's spouse, and the dependent children of the covered employee or former employee. This includes children covered through a Qualified Medical Child Support Order (QMCSO).

Extended Coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects Extended Coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, if applicable, special enrollment rights, and changes consistent with the qualifying midyear events listed in your handbook.

How long will Extended Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment (including long-term disability, leave of absence without pay), coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's or former employee's death, the employee's or former employee's divorce, or the loss of dependent child status under the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts up to 36 months from the month that Medicare entitlement occurred. It is the responsibility of the employee to advise the Group Benefits Administrator of Medicare entitlement within the 18 months before the qualifying event so that the appropriate duration of coverage may be offered. This notice describes the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time (see **"When and how must payment for Extended Coverage be made?"**); or;
- A qualified beneficiary becomes covered, after electing Extended Coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary*; or,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage*; or,
- A qualified beneficiary ceases to be disabled during the 11-month disability extension.*

Extended Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving Extended Coverage (such as fraud).

*It is the obligation of the qualified beneficiary to notify the Group Benefits Administrator within 30 days of the start of coverage under another group health plan or Medicare after the election

of Extended Coverage or loss of disability status during the 11-month disability extension. This should be sent in writing by a qualified beneficiary or representative to:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

Upon report of other group health plan coverage or entitlement to Medicare, Extended Coverage will be terminated at the end of the month in which that coverage begins. Upon report of loss of disability status during the 11-month disability extension, Extended Coverage will be terminated the first day of the month that is more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. Failure to report these events within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had the events been reported timely. Premiums paid during that period will be refunded, and any paid claims will be retracted.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Group Benefits Administrator for more information.

(Group Benefits Administrators--Insert the following section if the period shown on page one of this notice is less than 36 months)

How can the duration of Extended Coverage be increased?

If you elect Extended Coverage due to termination of employment or reduction of hours, an extension of the 18-month maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Group Benefits Administrator at **(Insert address and phone number of Group Benefits Administrator)**, of a disability or a second qualifying event in order to extend the period of continuation coverage from 18 up to 29 or 36 months. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage; however, one notice will cover all affected qualified beneficiaries.

o Extension due to disability

An 11-month extension of coverage may be available if any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at some time during the first 60 days of Extended Coverage and lasts at least until the end of the initial 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Notification of the disability determination must be given to the Group Benefits Administrator (see above) within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through the this notice or the General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary (e.g., employee, spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative).

If the disability ends prior to the end of the 11-month disability extension, it is the responsibility of the qualified beneficiary or his/her representative to notify the Group Benefits Administrator at the address noted previously within 30 days of the loss of disability status by providing documentation from the Social Security Administration. Failure to report the end of the disability status within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had it been reported timely (the first of the month that is more than 30 days after the determination). Premiums paid during that period will be refunded, and any claims paid will be retracted.

o Extension due to a second qualifying event

An 18-month extension of coverage will be available to spouses and dependent children who elect Extended Coverage due to the employee's termination of employment or reduction of hours if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee/former employee, divorce from the covered employee/former employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group Benefits Administrator if you want to exercise your rights to the additional Extended Coverage period. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., death, divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support, death certificate);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of additional Extended Coverage eligibility.

How is Extended Coverage elected?

To elect Extended Coverage, you must complete the Election Form and TLC Enrollment Form and furnish it to the Group Benefits Administrator designated at the beginning of this package. Each qualified beneficiary has a separate, independent right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Extended Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Extended Coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after

your group health coverage ends because of the qualifying event for which this notice was provided. You will also have the same special enrollment right at the end of Extended Coverage if you utilize the maximum period available to you.

How much does Extended Coverage cost?

Generally, qualified beneficiaries must pay the full cost of Extended Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage. The required monthly payment for each continuation coverage period for each option is described in an attachment to this notice.

When and how must payment for Extended Coverage be made?

o First payment for Extended Coverage

If you elect Extended Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment not later than 45 days after the date of your election. (If the Election Form is mailed, this would be 45 days from the postmark.) If you do not make your first payment within this time limit, you will lose all continuation coverage rights under the Plan. The first payment should include premiums for the period of coverage starting with the date coverage was lost due to the qualifying event and any regularly scheduled monthly premium that becomes due between your election and the payment date. You are responsible for making sure that the amount of your first payment is correct. After the initial payment, **(Insert your billing and/or premium collection requirements.)**

o Periodic payments for Extended Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. The amount due for each coverage month for each membership level is attached to this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each coverage month.

o Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days to make each periodic payment. If you fail to make your monthly payment by the end of the grace period (30 days after the start of the coverage period), you will lose all rights to continuation coverage under the Plan effective the first of the month for which payment was not received. Your premium payments should be sent to the former employer in the manner that they outline for you. Payments are considered made when mailed.

For more information

This notice does not fully describe Extended Coverage or other rights under the Plan. Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below

Contact information

o For information about Extended Coverage, initial notification of qualifying events, and initial enrollment:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

o To makes changes to Extended Coverage after initial enrollment:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

o The plan administrator is:

Department of Human Resource Management
101 N. 14th Street, 13th Floor
Richmond, VA 23219
Telephone: 804/225-2131

Keep your plan informed of address changes:

In order to protect your and your family's rights, you should keep the Group Benefits Administrator informed of any changes in your address and the addresses of family members that occur after initial enrollment. You should also keep a copy for your records, of any notices you send to either administrator listed above.

Attachments: HIPAA Certificate of Creditable Coverage
Premium Rate Information
TLC Enrollment Form